

GOOD CLINICAL DOCUMENTATION – ITS IMPORTANCE FROM A LEGAL PERSPECTIVE

Clinical documentation functions

Good clinical documentation:

1. ensures a complete record of health care is created;
2. substantiates decisions and management plans;
3. supports continuity of care;
4. facilitates proactive and reactive risk management;
5. helps prevent and defend legal claims; and
6. provides useful information for quality improvement and research purposes.

These functions are the most obvious and important from the perspective of Queensland Health's (QH) core business of health service delivery.

Clinical documentation practices to which this factsheet refers apply to all components of clinical health records including electronic and hard copies of progress notes, consent forms, clinical findings and investigations e.g. x-rays, scans, pathology etc.

Medico-legal implications

Patient confidentiality in QH services is strictly regulated under the *Hospital and Health Boards Act 2011* (Qld). Maintaining the confidentiality of health records must be a paramount consideration of QH staff at all times.

Records may be openly scrutinised in cases where, for example:

1. an allegation has been made that a health care practitioner has been negligent, or the care received has been sub-optimal, which results in a claim for compensation; and/or
2. investigations are conducted by the Coroner, the Health Ombudsman or another entity authorised to take evidence (such as the Medical Board of Australia or Nursing and Midwifery Board of Australia).

What is good clinical documentation?

Characteristics defining good clinical documentation from a medico-legal perspective are similar to those required from a clinical perspective.

That is, clinical notes should be accurate, contemporaneous, objective, detailed and legible.

The following examples highlight pitfalls that experience has shown arise in practice where these characteristics are not present.

Amendments and obliterations

Records should not be amended by deleting or obscuring notes in any way. To do so, may support an argument that there has been an attempt to cover up a mistake.

Any errors may be crossed out with a single line so that the original text remains legible. The amendment should be authenticated by the time, date and signature of the author, and an explanatory note written, for example, 'incorrect patient record'.

Contemporaneous notes

Notes that are written at a time considerably after an event are more likely to have their accuracy questioned.

The existence of notes that are not made contemporaneously may give rise to an inference that there has been a lack of attention to detail in the patient's care.

If notes cannot be made contemporaneously, staff should not attempt to back-date the health record. Notes should indicate the day and time that they were written.

Objective

Subjective statements about a patient's condition should be avoided. If an opinion is recorded, it should be limited to a clinical opinion backed up by the recording of objective data or observations.

The absence of recorded objective information limits a person's capacity to later verify the reasonableness of a diagnosis made or treatment provided. For example, notes indicating that a patient was '... pale, sweating, shaking', are preferable to those which simply state the patient was '... in shock'.

Derogatory comments

Clinical records are never an appropriate place for demeaning or derogatory comments, which are likely to embarrass, humiliate or anger a patient and/or those who are making a decision about a matter.

Recorded notes which may be damaging because of their derogatory nature may also concern colleagues. For example, a note that states a colleague '... arrived at 10.15pm' should never be supplemented to read '... arrived late at 10.15pm'.

A civil cause of action for defamation may arise if a person communicates any matter that is defamatory about another person to at least one other person. The courts have determined that an imputation (attributing something discreditable to a person) is likely to be defamatory when, in the

FACT SHEET

view of a reasonable member of the community, it causes injury to a person's reputation, their profession or trade, or makes others shun, avoid, ridicule or despise the person. A number of defences may be available to a person who communicates defamatory matter. These include situations where it is determined on the balance of probabilities that the matter in question is 'substantially true'.

Lack of details

In the absence of compelling evidence to the contrary, courts may take the view that a patient's recollection of events in the course of receiving treatment is more credible than that of an individual clinician providing that treatment.

The basis for reaching a conclusion of this nature is that the experience of receiving treatment may be more noteworthy and memorable to a patient, than it is for health care providers who are likely to have been involved in providing similar treatment to many patients.

For this reason, clinicians ought to make appropriately detailed notes in the health record about all aspects of health care provided and communication with consumers. For example, include explanations about conditions, treatment and associated, risks and potential side-effects.

Illegible notes are likely to weaken any argument that the treatment provided to a patient was reasonable.

In this instance, a claim would rely more heavily on individuals' recollections. Entries should be written in black ink, include the date and time at the commencement of the entry, be signed by the author and include the author's name and designation.

Avoid the use abbreviations or acronyms unless they are in common use and are commonly understood in health care.

The test of a good clinical record – Will this clinical record tell the whole story in a year?

This summary, prepared by the Legal Branch, Queensland Health, discusses matters of general principle only and is not a substitute for legal advice.

Any specific legal queries should be forwarded to Chief Legal Counsel at legal@health.qld.gov.au

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